

MEMORIAL HOSPITAL AT GULFPORT
CERTIFICATION BY CUSTODIAN OF MEDICAL RECORDS

STATE OF MISSISSIPPI

COUNTY OF HARRISON

The undersigned being duly sworn does state on oath as follows:

1. That she is the duly authorized custodian of the hospital medical records of MEMORIAL HOSPITAL AT GULFPORT and has the authority to certify records.
2. That the within and annexed are true and correct copies of requested portions from the medical records of MCBAY, GARY, DOB: 08/05/1976 as described in the correspondence received for these records.
3. The within and annexed records were prepared either by the personnel of the hospital or it's staff, physicians or by persons acting under the control either of them, in the ordinary course of hospital business at or near the time of the act, condition or event reported therein.


Signature of Custodian

SWORN AND SUBSCRIBED before me, this the 20 day of May 2009


Notary Public

MISSISSIPPI STATEWIDE NOTARY
MY COMMISSION EXPIRES SEPT. 8, 2014
BONDED THRU STEGALL NOTARY SERVICE



F/S P/T:ERT

MCBAY, GARY B 05311-00375 11/07/05 11/07/05 1

E R PHYSICIAN

GARY BRICE MCBAY NO INSURANCE

300 VZ COUNTY ROAD 3506

EDGEWOOD TX 75117-3466 04/29/09

	CODE	DESCRIPTION	QTY	
11/07	***250	PHARMACY		
	002834	TETANUS-DIPHTHERIA TOXOIDS-TD	1	49.90
		AREA TOTAL ***		49.90
11/07	***272	STERILE SUPPLY		
	013013	KIT URINE CULTURE CLEAN CATCH	1	48.50
		AREA TOTAL ***		48.50
11/07	***309	OTHER LABORATORY		
	075164	DRUG SCREEN-URINE RAPID (6 DRUGS)	1	500.60
		AREA TOTAL ***		500.60
11/07	***351	CT SCAN/HEAD		
	050017	CT BRAIN WITHOUT IV CONTRAST	1	1,693.50
11/07	050023	CT ORBIT/SELLA/P FOSSA/IAC W/O CX	1	1,693.50
		AREA TOTAL ***		3,387.00
11/07	***450	EMERGENCY ROOM		
	000100	INJECTION SQ/IM	1	33.60
11/07	060209	LEVEL VB-W DIAG TEST/PROCEDURE	1	1,008.10
		AREA TOTAL ***		1,041.70
11/07	***981	PROFESSIONAL FEES E/R		
	069321	E&M LEVEL III	1	230.40
		AREA TOTAL ***		230.40
		TOTAL CHARGES		5,258.10
		TOTAL PAYMENTS/ADJUSTMENTS		0.00
				5,258.10
				0.00
				5,258.10

Memorial
Healthcare

PATIENT REGISTRATION

E15 CP

MR	PATIENT NAME		ROOM NO		ACCOUNT NO	
0000359017	MCBAY, GARY BRICE		FC S -		05311-00375	
ADDRESS		CITY		STATE		ZIP CODE
09 SILVER CREEK		DE SOTO		TX		75115
SOCIAL SECURITY NO	ADMISSION DATE	ADM HOUR	ADM TYPE	ADM SOURCE	ACCO CODE	DISCHARGE DATE
444-998-4445	11/07/05	1502	1	7		ERT ER
PATIENT PHONE	BIRTHDATE	AGE	SEX	ORIGIN	MARITAL	RELIGION
(972) 223-2083	01-11-1955	29Y	M	4	S	UAF
SPOUSE'S NAME		NEAREST RELATIVE		RELATIONSHIP		PATIENT'S MAIDEN NAME
IN CASE OF EMERGENCY NOTIFY			RELATIONSHIP	ADDRESS	CITY	STATE ZIP CODE
MCBAY, GARY			FATHER	1109 SILVER CREEK	DE SOTO	
PRIMARY EMERGENCY PHONE	ALT EMERGENCY PHONE		PATIENT EMPLOYER			
(972) 223-2083			SELF			
ADDRESS OF EMPLOYER			CITY	STATE	ZIP CODE	PHONE
OTHER EMPLOYER			ADDRESS		CITY	STATE ZIP CODE
MCBAY, GARY BRICE						
GUARANTOR EMPLOYER			PHONE	GUARANTOR SOCIAL SECURITY NO		
SELF				444-998-4445		
ADDRESS OF GUARANTOR EMPLOYER			CITY	STATE	ZIP CODE	
ALTERCATION			ACCIDENT		DATE	TIME
			ALTERCATION W/SHERIFF DE		11/06/05	2000
NAME OF INSURANCE NO 1		NAME OF INSURANCE NO 2		NAME OF INSURANCE NO 3		
GROUP NAME		GROUP NAME		GROUP NAME		
GROUP NO / POLICYHOLDER		GROUP NO / POLICYHOLDER		GROUP NO / POLICYHOLDER		
STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	CITY STATE ZIP CODE
Admitting Diagnosis (Record here or on Physical Examination)						
Days						
PRINCIPAL Diagnosis						
Complications and/or Additional Diagnosis (List All)						
Principal Procedure						
All Other Procedures						
PRINTED BY: slh9337						
DATE 5/19/2009						
Consultation with						
DISCHARGE STATUS	<input type="checkbox"/> ALIVE	<input type="checkbox"/> AMA	<input type="checkbox"/> DIED			
	<input type="checkbox"/> TRANSFER	(AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO)				

Codes



CONSENT FOR ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

I, Gary Brice McBAY, give permission for such examination and treatment as the doctor(s) considers necessary or advisable for the care of MCBAY, GARY BRICE (Patient's Name).

I understand:

1. That examination and treatment may include x-rays, drawing blood, medical/surgical care, medicines, anesthesia, or other healing measures.
2. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above named patient.
3. If I/the above named patient deliver a baby during this hospital stay, I give permission for such examination and treatment of that baby as the doctor(s) considers necessary and advisable.
4. The practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. I have read and do understand this consent. I have had a chance to ask questions. The MHG staff answered my questions.

OTHER TERMS OF ADMISSION

I understand:

1. Memorial Hospital at Gulfport will send me/the above named patient a bill.
2. Each physician specialist who examines or treats me or the above named patient will send a separate bill.
3. Physicians working in the Hospital Emergency Department are not employees of the hospital. They work for Emergency Care Specialists of Mississippi, Ltd., a separate organization which is an independent contractor to Memorial Hospital at Gulfport.
4. I am responsible for calling my insurance company before admission. The insurance company may reduce my benefits if I do not follow procedures. The hospital will contact the insurance company only as a courtesy.
5. If I am in a Managed Care Plan requiring approval of a primary care physician (PCP), the hospital will contact the PCP for instructions. My insurer may not pay if I receive services without their approval. In this case, I may be personally responsible for all charges for these services.
6. Memorial Hospital will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

I understand:

1. I may place my personal property in the Hospital safe.
2. I am responsible for loss of or damage to personal property that I do not place in the Hospital safe.

Witness Wendy Hayd Date NOV 06 2005 Time 3:04 Signature of patient or person permitted to sign for patient Gary Brice McBAY Date NOV 06 2005

AUTHORIZATION TO RELEASE INFORMATION TO INSURER & ASSIGNMENT

I give permission to the Hospital to release medical information needed to process any claim related to this hospital stay against any of my insurance companies, including automobile or other liability insurance companies. MHG can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any worker compensation plan. This permission is good for the time provided in MHG's Health Information Management Department policy unless I deliver to the Hospital written notice of cancellation.

I assign all insurance benefits and all third party claims up to the amount owed to Memorial Hospital at Gulfport and to any physicians who provide services to me or the above named patient. I direct third party payors to pay all benefits directly to MHG and these physicians.

I have given current and correct information about my insurance or other benefit status to the Hospital.

Witness Wendy Hayd Date NOV 06 2005 Signature of patient or person permitted to sign for patient Gary Brice McBAY Date NOV 06 2005

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered the above named patient, I unconditionally guarantee payment for services not covered by insurance or a benefit program while a patient in Memorial Hospital at Gulfport. I guarantee this payment within 60 days of final billing. If I do not pay in full, within that time, MHG may refer the bill to an attorney or collection agency. If the bill is referred to an attorney, either by MHG or by a collection agency, I will be responsible for attorneys' fees of up to 33 1/3% in addition to the amount of the bill and legal interest from date 60 days after final billing. I understand that the Hospital has the right to examine credit bureau files for financial information on unpaid debts. MHG may inform any credit bureau of any hospital bill not paid within 60 days of final billing.

I have read and understand this financial agreement. I have had a chance to ask questions. The MHG staff answered my questions.

Witness Wendy Hayd Date NOV 06 2005 Signature of Patient or Guarantor of Account Gary Brice McBAY Date NOV 06 2005
Relationship to Patient _____

IF PATIENT IS UNABLE TO CONSENT TO THE FOREGOING OR IS A MINOR, COMPLETE THE FOLLOWING:

PATIENT IS A MINOR _____ YEARS OF AGE / IS UNABLE TO CONSENT BECAUSE _____

Witness _____ Date ____/____/____ Person Permitted to Sign for Patient _____ Date ____/____/____

Important Message from Medicare received: _____

Signature of Patient _____

Clerk Initials _____

Date _____

Memorial

Gary Brice McBAY

Consent for Admission
PRINTED BY: S1H9337
DATE: 11/07/2005
to Hospital and
Medical Treatment

PATIENT INFORMATION
ERT ERT -
MCBAY, GARY BRICE
11/07/2005 MR 0000359017
PHYSICIAN, E R
DOB: 02/06/1976 0531100375
M 29Y





Name McBay G Brice **DOB** 8-5-76 **Age** 29

Triage Level ☐ Emergent Priority ☒ Urgent Priority ☐ Non-Urgent Priority

Emotional Status: ☐ Comatose ☒ Calm ☐ Adv. Directive
☐ Anxious ☐ Combative ☒ Cooperative ☐ Living Will
☐ Hostile ☐ Other: ☒ DNR ☒ NONE

☐ 24-72 Hour Return ☐ Same Complaint ☒ New Complaint ☐ Call Back

On the Job Accident: ☐ Yes ☒ No **Date:** 11/2/05 **Time of Event:** 1442

Mode of Arrival: ☐ WIC ☒ Ambulatory ☐ Carried ☐ Ambulance

Arrived With: ☐ Friend ☐ Self ☐ Police ☐ Spouse ☐ Relative ☒ Parent

Treatment Prior to Arrival: ☐ None ☐ Yes: ☐ Ice ☐ IV ☐ O2 ☐ Spine Board/C-Collar ☐ Monitor ☐ Splint/dressing ☐ Other

Visual Acuity RT 20/ LT 20/ Both 20/ **TET Tox** **LMP** **WL** **Ht**

TB Screen ☐ Persistent Cough > 2 weeks ☐ Wt Loss ☐ Hx of TB ☐ Bloody Sputum ☐ Fever ☐ Night Sweats ☐ Anorexia ☒ No Symptoms ☐ In Foreign Country Recently

Date 11/2/05 **Time** 1442 **Chief Complaint: (In Patient's Words)** State awake last p - but i just all over body. 90% go w/ pain. Difficulty to face. Blurred eyes.

PAIN ASSESSMENT ☐ None ☐ Pt Uncooperative ☐ Unable to assess due to acuity

Pain now: (circle) 7

For PEDS, use faces scale; document as 0-10.

Private Physician(s): ☐ STAT (ED) Placement to Room # Reported to
☐ To Lobby after triage - Awaiting Bed Availability ☐ To Room # 215 at 1450 Report to
☐ LWBS at ☐ Refusal Obtained

Social History: Lives - ☐ Alone ☐ N.H. ☒ Family ☐ Homeless ☐ Yes ☐ No ☐ PPD ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Past Surgical History:

Past Medical History:

Family	Patient	Family	Patient
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hypertension
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Lung Disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> COPD
<input type="checkbox"/>	<input type="checkbox"/> CVA	<input type="checkbox"/>	<input type="checkbox"/> Bronchitis
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Nerves
<input type="checkbox"/>	<input type="checkbox"/> GI	<input type="checkbox"/>	<input type="checkbox"/> Back Problems
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> PVD
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Mental
<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Renal
<input type="checkbox"/>	<input type="checkbox"/> CAD	<input type="checkbox"/>	<input type="checkbox"/> Thyroid
<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> None
<input type="checkbox"/>	<input type="checkbox"/> HIV		

Comments: hypertension

Initial Vitals 12/4/90 **BP** 124/116 **Pulse** 118 **Temp** 98

ALLERGIES ☐ NONE KNOWN

Food, Medication, Latex, Type, Iodine, Other Myocardial Infarction

Mental Status ☐ Alert ☐ Uncooperative ☒ Oriented X 3 ☐ Combative ☐ Lethargic ☐ Drowsy ☐ Unresponsive ☐ Disoriented

Speech ☒ Coherent ☐ Incoherent ☐ Slurred ☐ Silent

Respiratory ☐ Regular ☐ Labored ☐ Shallow ☐ Retractive ☐ Absent

Skin Color ☒ Normal Pink ☐ Ashen ☐ Cyanotic ☐ Flushed ☐ Pale ☐ Jaundiced

Skin ☒ Dry ☐ Moist ☐ Diaphoretic

Skin Temp ☐ Warm ☐ Hot ☐ Cool

Pupils ☐ N/A ☒ Equal ☐ Unequal ☐ RT ☐ LT

Special Needs or Physical Ability Needs ☐ Teeth/Mouth problems ☐ Deaf Y/N Interpreter ☐ Foreign language Interpreter ☐ Financial ☐ Emotional ☐ Spiritual ☐ Cultural

Memorial
 Building a Healthier Community

Emergency Department Nursing Record

PRINTED BY: SM9337
 DATE: 5/19/2009

cr brain
crickets/503
do

MCBAY, GARY BRICE
 PHYSICIAN, E R
 MR 0000359017

11/07/2005

ERT M 29Y

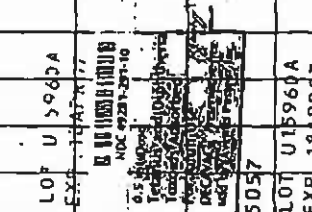
0531100375

Patient Name _____ Account # _____ Date: _____

Time	T	P	R	BP	Time	T	P	R	BP

Ongoing Assessment Treatment

1435 Pt multiple bruises - blackened eyes Lt > Rt happened early AM at Police Station - nose is not straight abrasion across lt forehead abrasion on Rt forehead elbow minor knee contusions - Dr. Killebrew to see pt @ 1510 CT 6 ^{100% VSA} ^{100% VSA} brain ordered - as held @ 1535 at ECT Amb & H EDT, 1555 to Rm from CT & H EDT 1730 was obtained & delivered to lab to come in care of family to see tomorrow for results - pt @ 1740 x 3 fully ambulatory - no acute ct raised

Time	Medication	Dose	Mode	Site	Signature	Time	Medication	Dose	Mode	Site	Signature
1530	dt 0.5cc	IM			<i>[Signature]</i>						
						<p>MCBAY, GARY BRICE PHYSICIAN, E R MR 0000359017 11/07/2005 ERT M 29Y 0531100375</p>					
LOT U 5903A EXP 11/17/07	LOT U 5903A EXP 11/17/07	LOT U 5903A EXP 11/17/07	LOT U 5903A EXP 11/17/07	LOT U 5903A EXP 11/17/07	LOT U 5903A EXP 11/17/07						

I N F U S I O N	Amt	Solution	Additive	Device	Site	Rate	Start	Stop	Total Amount	Signature	Intake	Output

Disposition 1732 AM/PM	<input type="checkbox"/> Admitted Time	Room No.	Ready Room Time	<input checked="" type="checkbox"/> Discharged via	<input checked="" type="checkbox"/> Ambulatory	<input type="checkbox"/> Wheelchair
				<input type="checkbox"/> In Arms	<input type="checkbox"/> Ambulance	

PRINTED BY: slh9337

DATE 5/19/2009

HISTORY AND PHYSICAL		Time: _____	
/PHI: _____		FMH: _____	
		SH: _____	
<p>29yo involved in altercation - police last pm - Den chest, arms, face</p>			
<p>PE lungs - clear C/R RSR N/V intact Bruising over arms bilaterally - Bruising chest large (L) periorbital hematoma Bruising under (R) eye</p>			
		ROS: • if neg. Gen: 0 Card: 0 Resp: 0 Renal: 0 End: 0 GI: 0 Neuro: 0 Eye: 0 ENT: 0 Skin: 0 Psych: 0 Ms/St: 0	
		ORDERS Test Order Tm/Int. CX MAEN 3 Ser uric 3 STUDS	
3: _____		X-RAY	Nurse Order Tm/Int.
		EKG	✓ 66.5cc 141110W
		U.S./C.T.	
DIAGNOSIS: Nasal Fracture			
<input checked="" type="checkbox"/> May Discharge <input type="checkbox"/> Admit Time 1832	<input type="checkbox"/> Transfer <input type="checkbox"/> AMA	Condition on Discharge <input checked="" type="checkbox"/> Stable	<input checked="" type="checkbox"/> I HAVE REVIEWED THE NURSES ASSESSMENT AND HISTORY <input type="checkbox"/> See Dictated Notes Physician's Signature _____
Patient Instructions <input type="checkbox"/> Sprain & Fracture, Severe Bruises <input type="checkbox"/> Medications <input type="checkbox"/> Head Inj (adult) <input type="checkbox"/> Fever <input type="checkbox"/> Back/Neck Inj <input type="checkbox"/> Vomiting/Diarrhea <input type="checkbox"/> Common Cold/Viruses <input type="checkbox"/> Sedation Instruction <input type="checkbox"/> Reducing High Fever <input type="checkbox"/> Orthopedic Appliance <input type="checkbox"/> Head Inj (Child) <input type="checkbox"/> Eye Inj <input type="checkbox"/> Wound Care/Animal Bite <input type="checkbox"/> Burns <input type="checkbox"/> Other _____			
DISCHARGE INSTRUCTIONS: Take meds as ordered return as needed			
Follow Up <input type="checkbox"/> Make an appointment to see your regular physician <input type="checkbox"/> Follow-up Visit in Emergency Department <input type="checkbox"/> Have Sutures Removed in _____ Days			
PATIENT/S/O VERBALIZED UNDERSTANDING OF INSTRUCTIONS Nurse Signature _____		I HAVE READ AND UNDERSTAND INSTRUCTIONS AND HAVE RECEIVED A COPY OF THEM Patient Signature _____	

Memorial
 Building a Healthier Community

Emergency
 Department
 Physician
 Record
 PRINTED BY: slh9337
 DATE: 5/19/2009

MCBAY, GARY BRICE
 PHYSICIAN, E R
 MR 0000359017



11/07/2005
 DEPT 1100373
 ERT M 29Y
 0531100375

* * * * * MHG Cumulative Summary Report * * * * *

Patient: MCBAY, GARY BRICE	Admit Loc: ERT	Facility: ER Trauma
Age: 29Y Sex: M		** MEDICALR DISCHARGE REPORT **
DOB: 000000		*** PERMANENT REPORT - DO NOT DISCARD ***
MR#: 0000359017	Admit#: 0531100375	Dsch Date: 11/07/05
Admit Phys: PHYSICIAN, E R DE	Order Phys: KILLEBREW, LARRY MD	RunID: R1624489
Attend Phys: KILLEBREW, LARRY MD	Consult Phys:	Reported: 11/10/05 03:11

***** TOXICOLOGY *****

	11/07/05 17:30	REF RANGE	UNITS
Amphet	Negative	Negative	
Barb	Negative	Negative	
Benzo	Negative	Negative	
Cannab	Negative	Negative	
Cocaine	Negative	Negative	
Opiate	Negative	Negative	
Comment	See Note ¹		

¹Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours..

Patient: MCBAY, GARY BRICE

Page 1 of 1

Clinical / Pathology Laboratory * Memorial Hospital at Gulfport * 4500 13th Street * Gulfport, MS 39501
Phone: 228-575-2300 * Fax: 228-575-2387

MHG Dept of Pathology: P Saccoccia, Jr, MD C Stonaker, MD M.J Gandour, MD J Causey, MD
PRINTED BY: slh9337

***** DATE ***** 5/13/2009 ***** TOXICOLOGY *****

MCBAY, GARY BRICE DOB: ~~01/15/76~~ AGE: 29Y
MR# G0000359017 CI# 834729 ACCOUNT # 0531100375
RV: ERT
TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in #	Order	Exam	
834729	0001	50017	CT BRAIN WITHOUT IV CONTRAST
Ord Diag: trauma			

CT BRAIN WITHOUT IV CONTRAST:

CLINICAL HISTORY PROVIDED: Altercation with head trauma.

Multiple sequential sections were obtained through the brain and there is a large left temporoparietal scalp hematoma. There is no associated fracture.

Brain attenuation is normal with no focal ischemic infarct, mass, or hemorrhage. Ventricular system is normal and midline structures are midline. There is no acute extraaxial fluid accumulation.

There is some mucosal thickening of the ethmoid air cells bilaterally.

IMPRESSION:

THERE IS A RELATIVELY LARGE LEFT TEMPOROPARIETAL SCALP HEMATOMA OR CONTUSION. THERE IS NO ASSOCIATED FRACTURE OR ACUTE INTRACRANIAL ABNORMALITY.

THERE IS SOME MUCOSAL THICKENING OF THE ETHMOID AIR CELLS LATERALLY.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.

PRELIMINARY UNLESS RELEASED

11/07/05 2016

Typed By: SKY

Typed On: 11/07/05 1647

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337

DATE 5/19/2009

MCBAY, GARY BRICE DOB: 01/11/81 AGE: 29Y
MR# G0000359017 CI# 834748 ACCOUNT # 0531100375
RV: ERT
TYPE: ERT LOC: ERT EXAM DATE: 11/07/05
ORD: KILLEBREW, LARRY MD ADM: PHYSICIAN, E R MD
ATT: PHYSICIAN, E R MD

Chk-in #	Order	Exam	
834748	0003	50023	CT ORBIT/SELLA/P FOSSA/IAC W/O CX
Ord Diag: ALTERCATION			

CT OF THE ORBITS:

CLINICAL HISTORY PROVIDED: Altercation. Orbital injury.

Multiple sequential sections were obtained through the orbits and there is comminuted nasal bone fracture with deviation of the nasal septum to the right posteriorly with spurring which is chronic in appearance. I do not see a definite orbital fracture. There is mucosal thickening ethmoid air cells bilaterally and frontal sinuses more on right than left. There is also air within the soft tissues over the anterior and lateral right maxillary sinus although no definite orbital floor or sinus fractures are seen. There is soft tissue swelling over the orbits and face bilaterally.

IMPRESSION:

COMMINUTED NASAL BONE FRACTURE. MUCOSAL THICKENING BILATERAL ETHMOID AND FRONTAL SINUSES WHICH IS MORE PROMINENT ON RIGHT THAN THE LEFT, PROBABLY RELATED TO TRAUMA AND MILD BLEEDING. SOFT TISSUE AIR OVER THE RIGHT MAXILLARY SINUS BUT NO DEFINITE ORBITAL OR MAXILLARY FRACTURE IS IDENTIFIED. PROMINENT DEVIATION OF THE NASAL SEPTUM APPEARS CHRONIC.

/Read By/ MILTON R RAINES, M.D.

/Released By/ MILTON R RAINES, M.D.

PRELIMINARY UNLESS RELEASED

11/07/05 2016

Typed By: SKY

Typed On: 11/07/05 1650

DRS. BARRETT, JUSTICE, TIPTON, DIAZ, MASSONY, LOVELL, RAINES, COREY,
LAWSON, STOREY, RADIOLOGISTS
FINAL

Page :1

RADIOLOGY REPORT

PRINTED BY: slh9337

DATE 5/19/2009



INTERDISCIPLINARY PATIENT/FAMILY EDUCATION FLOW SHEET

INITIAL	PROVIDER SIGNATURE	INITIALS	PROVIDER SIGNATURE
	<i>[Signature]</i>		

DOCUMENTATION LEGEND:

Topic				
M - Medications	P - Procedure	D - Diet	A - ADL	FDI - Food/Drug Interaction
E - Equipment	C - Consents	DX - Diagnosis	T - Treatment	Other _____
Readiness to Learn:				
Ability to Understand Verbal Instruction:	VP - Poor	VA - Average	VG - Good	
Cognitively Able to Understand:	CP - Poor	CA - Average	CG - Good	
Ability to Understand Written Instruction:	WP - Poor	WA - Average	WG - Good	
Barriers to Learning				
P - Physical	V - Visual	C - Cognitive	M - Motivation	R - Religious
R - Reading	L - Language	CL - Cultural	AR - Age Related	E - Emotional
A - Auditory	N - None			
Who				
Patient	F - Family	O - Other		
Learning Method Used				
D - Demonstration	TV - Video/TV/Audio	W - Written	GR - Group Work	
P - Pamphlet	V - Verbal Instruction	MED - Medication Instruction Sheet	O - Other	
Comprehension				
1. Verbalized or demonstrated understanding.		4. Medical condition limits understanding.		
2. Not receptive/cooperative.		5. _____		
3. Needs further instruction.		6. _____		

DATE/ TIME	PROVIDER INITIAL	TOPIC	READINESS TO LEARN	BARRIERS TO LEARNING	WHO	LEARNING METHOD USED	COMPREHENSION	PREFERRED LEARNING METHOD:
								INFORMATION TAUGHT
11/7/05 1740	<i>[Signature]</i>	MR T	UG	N	to	UG	1	Medication as study prece- dure was as directed with AA JV



Interdisciplinary
Patient/Family
Education Flow Sheet

PATIENT INFORMATION

ERT
MCBAY, GARY BRICE
11/07/2005 MR 0000359017
PHYSICIAN, E R
DOB 02/08/1976 0531100375
M 29Y



AZ FROM DEFAULT Sent 11/08/05 at 10:20:00

Page 1

* * * * * MHG PATIENT INQUIRY Demand Report * * * * *

Patient: MCBAY, GARY BRICE

Loc: ERT

Facility: ER Trauma

Age: 29Y Sex: M DOB: [REDACTED]

** PI DEMAND REPORT **

MR#: 0000359017

Admit#: 0531100375

Admit Phys: PHYSICIAN, E R DE

Order Phys: KILLEBREW, LARRY MD

RunID: R1621536

Attend Phys: KILLEBREW, LARRY MD

Consult Phys:

Reported: 11/08/05 10:19

* * * * * TOXICOLOGY * * * * *

11/07/05

17:30

REF RANGE UNITS

Amphet	Negative	Negative
Barb	Negative	Negative
Benzo	Negative	Negative
Cannab	Negative	Negative
Cocaine	Negative	Negative
Opiate	Negative	Negative
Comment	See Note ¹	Negative

¹Results are for medical / screening purposes only. Confirmation testing by reference lab available if ordered within 48 hours

Patient: MCBAY, GARY BRICE

Page 1 of 1

Clinical / Pathology Laboratory * Memorial Hospital at Gulfport * 4500 13th Street * Gulfport, MS 39501
Phone: 228-575-2300 * Fax: 228-575-2387

MHG Dept. of Pathology:

P. Saccoccia, Jr., MD

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